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PERSONAL INFO SHEET

CHILD INFORMATION **DATE** _____

Child's Full Name (First, Middle, Last) _____ *Preferred* _____

Date of birth _____ Age _____ Optional: Sex/Gender _____ Race/Ethnicity _____

Address _____ City/State/Zip _____

Last 4 digits of SSN: _____ Referred by _____

Who has LEGAL custody (name ALL) _____

If joint custody, explain conditions _____

Emergency Contact _____
Name Relationship Phone#

PARENT/GUARDIAN #1

Name of Parent/Guardian _____ Relationship to child _____

Parent/Guardian Employer _____

Telephone: Daytime _____ Detailed msgs okay? ..... ☐ Yes ☐ No

Evening _____ Detailed msgs okay? ..... ☐ Yes ☐ No

Cell/Pager _____ Detailed msgs okay? ..... ☐ Yes ☐ No

Email _____ Detailed msgs okay? ..... ☐ Yes ☐ No

Address _____

City/State/Zip _____

PARENT/GUARDIAN #2

Name of Parent/Guardian _____ Relationship to child _____

Parent/Guardian Employer _____

Telephone: Daytime _____ Detailed msgs okay? ..... ☐ Yes ☐ No

Evening _____ Detailed msgs okay? ..... ☐ Yes ☐ No

Cell/Pager _____ Detailed msgs okay? ..... ☐ Yes ☐ No

Email _____ Detailed msgs okay? ..... ☐ Yes ☐ No

Address _____

City/State/Zip _____

HEALTH INSURANCE INFORMATION

Guarantor's Name _____ Date of Birth _____

Employer _____ Last 4 digits of SSN: _____

Employer Address/Phone _____

Primary Insurance _____ Policy # _____

Address _____ Group # _____

Secondary Insurance _____ Policy # _____

Address _____ Group # _____

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO THE INSURANCE CARRIER(S) LISTED ABOVE. I AGREE TO MAKE ANY CO-INSURANCE PAYMENTS REQUIRED BY MY POLICY AT THE TIME OF SERVICES. I UNDERSTAND THAT I WILL BE BILLED FOR SESSIONS THAT ARE NOT CANCELLED WITHIN 24 HOURS. I ALSO UNDERSTAND THAT A $25 FEE WILL BE ADDED TO ACCOUNTS REFERRED TO A COLLECTIONS AGENCY DUE TO NON-PAYMENT.

_____ _____

Signature of responsible party **Date**

Name of Client _____

CHILD DATA SHEET

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PRESENTING CONCERNS

1. What is the main reason you seek counseling for your child at this time? _____

Check any symptoms associated with these problems that concern you:

- ☐ Anxiety / Frustration
- ☐ Boredom/Disinterest
- ☐ Emotional Numbness
- ☐ Feelings of Fear or Dread
- ☐ Guilt or Shame
- ☐ Irritability
- ☐ Low Energy
- ☐ Physical complaints (please specify)
- ☐ Sadness
- ☐ Social Withdrawal
- ☐ Overeating / ☐ Under eating
- ☐ Weight Gain / ☐ Weight Loss
- ☐ Body Image Issues
- ☐ Racing Thoughts
- ☐ Suicidal Thoughts
- ☐ Trauma History
- ☐ Anger
- ☐ Behavior Changes
- ☐ Confusion
- ☐ Dissociation
- ☐ Grandiosity
- ☐ Hallucinations
- ☐ Increase in Substance Use
- ☐ Obsession
- ☐ Paranoia
- ☐ Rage
- ☐ Violent Behavior
- ☐ Educational Problems
- ☐ Employment Problems
- ☐ Financial Problems
- ☐ Housing Problems
- ☐ Legal Problems
- ☐ Social Problems

Details: _____

2. Describe your child's (check one):

Current attitude toward life	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*
Best attitude this past year	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*
Hopefulness for things getting better	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*
Ability to think clearly	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*
Ability to feel many emotions	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*
Quality of friendships	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*
Belief counseling will help	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*

3.

Overall physical condition	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*
Diet/nutrition	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*
Exercise/ activity level	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*
How you feel about your body	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*
Work efficiency	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*
Sleep (check all that apply)	☐ *Regular*	☐ *Adequate*	☐ *Peaceful*	
	☐ *Irregular*	☐ *Inadequate*	☐ *Disrupted*	

4. When did these problems start? _____

5. Have you previously sought help for your child for these symptoms or problems? If so, what has been helpful? _____

6. Please describe your or your child's:
   …central focus/ concern(s). _____
   _____
   …belief(s) about the cause of the current problems. _____
   _____
   …expectations/ goals for therapy. _____
   _____
7. What concerns, beliefs, or observations have others expressed regarding your child's current problems? What do they think should happen?: _____
   _____
8. How do your child's issues or problems affect other household or family members?: _____
   _____
   Currently supportive family/household relationships:
   _____
   Currently conflicted family/household relationships:
   _____

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TREATMENT HISTORY

9. Has your child ever seen another mental health professional?
   (counselor, psychiatrist, marriage counseling) ..... ☐ Yes ☐ No
   Who/ when/ how long/ reason: _____
   _____
10. Has your child ever been hospitalized for mental/ emotional/ psychiatric problems or substance abuse? ..... ☐ Yes ☐ No
11. Name of child's primary doctor: _____
    _____
    Location/Phone#: _____
    _____
12. Does your child take any prescription or other medications?
    (include any vitamin or herbal supplements or teas) ..... ☐ Yes ☐ No
    Name/ dosage/ frequency/ reason: _____
    _____
13. Any current or past medical issues (*e.g. seizures, headaches, extreme confusion, diabetes, concussion, head injury, other*)?..... ☐ Yes ☐ No
    Details: _____
    _____
14. Does your child take non-prescription or recreational drugs or drink alcoholic beverages?..... ☐ Yes ☐ No
    Drugs used, amount, and frequency: _____
    _____

BACKGROUND INFORMATION

15. Has your child:
    … ever been abused or assaulted?..... ☐ Yes ☐ No
    … ever been abusive or assaultive to others? ..... ☐ Yes ☐ No
    … ever attempted suicide?..... ☐ Yes ☐ No
    … had any thoughts of harming self or others?..... ☐ Yes ☐ No
    Details: _____
    _____

Name of Client _____

16. Significant events or circumstances; indicate your child's age for each:

    Significant recent events/ circumstances: _____

    _____

    Other significant lifetime events/ circumstances: _____

    _____

17. Describe your child's current household(s) and any recent changes (*please include all adults and children; provide names, ages, and relationship to child*):

    _____

    _____

18. Atmosphere of your child's current and/or recent household(s) (*e.g. loving, supportive, chaotic, abusive, lonely, tense, volatile*): _____

    _____

19. Cultural or ethnic background of your child's household(s) *(region of the country/ world; urban vs. rural; language(s) in home; ethnicity/ race; immigrant or refugee family history):*

    _____

    _____

20. Does your child have a best friend? _____

    _____

    Describe your child's social support and other important relationships *(e.g. other relatives, important adults such as teachers or neighbors, your child's close friends, etc.)*: _____

    _____

PERSONAL

21. Your child's hobbies or leisure activities *(what your child likes to do for fun)*:

    _____

    _____

22. If you have pets, please list them and describe: _____

    _____

23. Your child's strengths: _____

    _____

24. Your child's weaknesses: _____

    _____

25. At what age did your child:

    …begin dating?: _____ become sexually active? _____

    Any miscarriages/ abortions? _____ Sexually transmitted diseases? _____

26. Is religion/spirituality important to your child?..... ☐ Yes ☐ No

    Religious/spiritual "preference": _____

    Your child's satisfaction ☐ *Excellent* ☐ *Good* ☐ *Fair* ☐ *Poor*

OTHER INFORMATION

27. Is your child in school? ..... ☐ Yes ☐ No

    Highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12

    Name of school: _____

    Name of teacher: _____

    Learning Disabilities: _____

28. Has your child ever been employed? ..... ☐ Yes ☐ No

    Occupation, Employer, how long: _____

For Office Use Only

Name of Client _____

29. Any arrests or charges against your child? ..... ☐ Yes ☐ No
Date(s) and charge(s): _____ Upcoming Court Date(s): _____

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FAMILY/GENETIC HISTORY

30. Describe your family/genetic history ***(indicate who, and type of problem)***:
Physical illnesses: _____

Mental or emotional illnesses: _____

Alcohol or drug use problems? _____

NOTES

Please use the space below or the other side for any other information I should know. You many continue on the backside if needed.

By signing below I attest that I have the legal right to make decisions regarding the care of the above named child. I attest that the above information is accurate to the best of my knowledge. I agree to allow the treatment provider(s) of Apsara Counseling Services Inc. to provide Mental Health and Behavioral Health treatment to the above named child.

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature (if needed) Date

_____ _____
Counselor Signature Date